

Dr Shashi Arora

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

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Summary of findings

Overall summary

Baring Road Medical Centre is a general medical practice in the London borough of Lewisham with a list of approximately 6,255 patients. The borough is characterised by relatively high levels of deprivation and is the 16th most deprived out of 326 local authorities in England. Life expectancy for both males and females is lower than the England average with early deaths due to heart disease, stroke and cancer.

We carried out an announced inspection on 7 July 2014. Our inspection team was led by a CQC Inspector, accompanied by two specialist advisors; a GP and a Healthcare Manager and an expert by experience. Before our inspection we reviewed a range of information we held about the practice from our Intelligent Monitoring System. We met with NHS England, NHS Lewisham Clinical Commissioning Group (CCG) and Healthwatch Lewisham and reviewed the information they gave to us. During our inspection we spoke with a range of staff including GP's, nurses, a healthcare assistant and management and reception staff. We also spoke with patients and a representative from the practice's patient participation group (PPG).

The practice was effective, caring, responsive and well-led. Improvements were required for the service to be safe. This was because disclosure and barring service (DBS) checks had not been undertaken for appropriate staff members, including non-clinical staff who are required to chaperone patients.

The practice had measures in place to protect and promote the safety of patients in their care. They had procedures for reporting, recording and learning from significant incidents. Staff completed safeguarding training and were aware of the processes to follow if they suspect a patient was at risk of harm. Vaccinations and other injectable medicines were stored correctly at the practice. Staff received infection control training and infection control audits were conducted. Staff were trained to deal with medical emergencies and emergency equipment and medicine was available.

Clinical staff attended weekly meetings to discuss complex medical cases and had access to up-to-date guidelines to ensure treatment was delivered in line with current best practices. The practice engaged in clinical audit to review services and to improve outcomes for patients. Staff received annual appraisal to review training needs and to promote further professional development. The practice had regular meetings with the wider multi-disciplinary team to develop integrated care pathways for their patients.

Patients considered that they are treated with dignity and respect by most staff at the practice. They described positive experiences with the care provided to them by clinical staff and that they were provided with relevant information and explanation about their treatment options.

Staff were aware of their responsibilities in assessing a patient's capacity to make decisions about their care.

The practice met the needs of different population groups. For example, the practice had links with social services and community matron to provide holistic care for older people. Patients with long term conditions, people experiencing poor mental health and patients with learning disabilities were invited for annual reviews. Extended hour appointments were available weekly for patients unable to attend the practice in routine opening hours because of work commitments. The practice nurses offered immunisations to children and babies with good uptake rates.

There was a culture of discussion and learning at the practice and staff felt generally well supported by the management team. Patient feedback was gathered from the patient reference group (PPG) and patient surveys and there was evidence of improvements made to the service as a result of this feedback. The practice had a complaints policy and all complaints received in the previous year were reviewed at an annual meeting. There was a contingency plan in place to manage any significant disruption to services.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

There were mechanisms for reporting, recording and learning from safety incidents and significant events. Staff had completed child protection training to the appropriate level for their role and were aware of the safeguarding procedures they should follow if they suspected a patient in their care was at risk from harm. Staff received infection control training. Infection control audits were conducted and the latest infection control audit performed in July 2014 highlighted areas for improvement. The practice maintained safe storage of medicines and vaccinations.

Arrangements were in place to deal with foreseeable medical emergencies and all staff had received training in basic life support.

An up to date contingency plan to manage significant disruption to services was in place. The practice had a recruitment process, however, not all staff files contained completed disclosure and barring (DBS), including the practice nurse's and no assurance was provided by the practice that one had been completed.

Are services effective?

Clinical staff had access to up-to-date guidelines and regularly attended clinical meetings to discuss patient cases to maintain best practice. Clinical audit was performed to monitor services and improve outcomes and referrals made to other services were reviewed regularly to ensure they were appropriate.

Staff received annual appraisal to identify training needs and plan professional development.

Multi-disciplinary meetings were held monthly to discuss patients with complex needs and co-ordinate care. The practice worked with other local practices and community services in an NHS Lewisham Clinical Commissioning Group (CCG) led scheme to prevent avoidable admissions to hospital.

The practice had a pro-active approach to health promotion and invited patients to health care assistant (HCA) led health checks. Health checks were carried out at home by HCAs for house bound patients. Flu immunisations and childhood vaccinations offered by the practice received a good uptake rate.

Are services caring?

Patients we spoke with told us that staff treated them with dignity and respect. They described positive experiences of care provided by clinical staff. Reception staff were observed to treat patients with

Summary of findings

courtesy and respect when answering patient telephone enquiries and when they attended in person. Consultation rooms were equipped to maintain patient's privacy and a chaperone service was available if patients required.

Patients told us that the GP's provided them with relevant information and explanation about their treatment options. Patient information and health related literature was available in the practice waiting room. Clinical staff we spoke with were aware of their responsibilities to assess a patient's capacity and maturity to make decisions about their care.

Are services responsive to people's needs?

Extended hour appointments were offered once weekly for patients unable to attend the practice in normal working hours. Ante-natal care was provided by visiting community midwives twice weekly. Post-natal checks were performed at a weekly clinic by the GP partner to meet the needs of new mothers. Childhood immunisations were offered by the practice nurse and received a good uptake rate. Older patients had a named GP for their medical management.

Practice nurses performed annual checks for patients with chronic conditions and learning disabilities. One of the practice nurses with mental health training provided annual reviews of patients experiencing poor mental health, which included routine blood tests and screening for symptoms of depression.

The practice had emergency appointments available daily with the on call GP. A telephone triage system was in place which offered patients a GP call back service to discuss medical concerns over the phone. Routine appointments and repeat prescriptions could be arranged online through the practice website. Some patients described difficulty accessing appointments but the practice was in the process of dealing with this issue and had employed a locum GP to commence work in August 2014.

The practice complaints procedure was detailed in the practice information leaflet and on the website. Complaints were reviewed annually at a complaints meeting and learning points were discussed and disseminated to all staff.

Are services well-led?

Staff described a culture of learning and felt the practice was generally well managed. Staff had clearly defined roles and responsibilities. Clinical governance procedures were in place including clinical audit and learning from significant events and complaints, to ensure quality and improvement of services.

Summary of findings

Patient feedback was gathered through the patient participation group (PPG) and regular patient surveys. The practice had evidence of improvement to their services as a result of patient feedback. Staff feedback was encouraged through regular weekly staff meetings. Staff felt well supported by the management team at the practice. Annual appraisal was performed to identify staff training needs.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Patients over 75 years of age had a named GP for their medical management. The practice had access to community services and memory clinics to support the needs of older people with dementia. The practice had links with social services and community matron to provide holistic care for older people.

People with long-term conditions

The practice ran annual medical assessment reviews, or sooner if required, for patients with long term conditions. A re-call system was used to flag when a patient was due to be seen and a letter was sent inviting them to book an appointment. Monitoring assessments were conducted by practice nurses appropriate to the patient's long term medical condition.

Mothers, babies, children and young people

The practice provided community midwife led weekly ante-natal clinics and GP led post-natal clinics. Baby and child immunisations were offered by the practice with good uptake rates. Health visitors attended the practice weekly for child health promotion. Monthly safeguarding meetings were held with the health visitors to discuss any potentially vulnerable patients.

The working-age population and those recently retired

Extended hour appointments were available weekly for patients unable to attend the practice in normal working hours. GP telephone call back triage assessments were available daily.

People in vulnerable circumstances who may have poor access to primary care

Annual health checks were offered to patients with learning disabilities and the practice had strong links with their carers.

People experiencing poor mental health

The practice held annual reviews of patients who experienced poor mental health which was provided by one of the practice nurses with training in mental health. The practice had links with the community mental health team to discuss cases if required.

Summary of findings

What people who use the service say

The results of the practice's patient experience survey showed 56% of patients who responded had a good or excellent experience at the practice and 65% of these felt the treatment they received was good or excellent. The National GP patient survey 2013 results demonstrated 79% of respondents found it easy to get through to the surgery on the phone and 80% were able to secure an appointment when required.

Patients we spoke with during our visit told us staff at the practice were respectful and polite. They felt they received compassionate care and were treated with dignity. Patients also told us they felt involved and supported in making decisions about their care. However, some patients we spoke with and some Care Quality Commission (CQC) comment cards that were returned to us, expressed difficulties in making an appointment and getting through to the practice by phone.

Areas for improvement

Action the service **MUST** take to improve

Review Disclosure Barring Service (DBS) check status of all staff to ensure checks have been undertaken for appropriate staff members, including non-clinical staff who are required to chaperone patients.

Action the service **SHOULD** take to improve

Review chaperone training completion for all reception staff.

Implement colour coded cleaning materials and equipment as highlighted a requirement in the latest infection control audit conducted by an external assessor in July 2014.

Review general cleaning schedule recording documentation.

Allocate or replace key to fridge where vaccinations are stored.

Review fire escape route to ensure accessibility to wheelchair users.

Arrange formal internal supervision for nursing staff.

Review contingency plan to ensure essential services contact details are included.

Identify patient information literature that could be used to assist patients with learning difficulties to understand investigative procedures to promote their health and well-being.

Review the positioning of the information notice board in the waiting area to ensure visibility to all patients.

Review building and equipment maintenance records to ensure current status.

Outstanding practice

- Home visits were carried out by healthcare assistants to perform health checks for housebound patients.
- Integrated extended services, such as a visiting dietician and access to counselling services were available at the practice.
- Practice nurses with mental health training performed annual health checks for patients experiencing poor mental health.

Dr Shashi Arora

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC Inspector). The lead CQC inspector was accompanied by two specialist advisors; a GP and a Healthcare Manager and an expert by experience. They were all granted the same authority to enter Baring Road Medical Centre as the CQC inspector.

Background to Dr Shashi Arora

Baring Road Medical Centre is a general medical practice situated within the geographical area of NHS Lewisham Clinical Commissioning Group (CCG). The practice is located in the London Borough of Lewisham. As of 7 July 2014, 6,255 patients were registered at the practice; of these 24 per cent of patients are aged 0-18, 32 per cent aged between 18-40, 36 per cent aged between 40-70 and 8 per cent aged over 70 years.

The practice provides primary care services including diagnostics and screening procedures, family planning and minor surgical procedures. It offers a range of services for patients across all ages. A number of options are available for people to access advice, care and treatment including same day appointments, advance appointment bookings and daily telephone call back triage with a GP.

The practice team includes one female GP partner, two salaried GP's one male and one female who is currently on maternity leave. This post is currently covered by a locum GP. There are two non-prescribing practice nurses, two health care assistants, a practice manager, reception and administrative staff.

The practice is open Monday to Friday 8am - 1pm & 2.00pm – 6.30pm, with extended opening hours on a Wednesday from 6.30pm – 8.00pm for pre-booked appointments only. An on-call GP is available by telephone contact for emergencies when the practice is closed for lunch. Out of hours arrangements were provided on the practice's website and a recorded telephone message directed patients to the out of hours service.

The practice operates from purpose built premises spread over three floors. Access to the building is suitable for people who use a wheelchair and a lift is available to access upper floor consultation rooms.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This practice had not been inspected before.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)

Detailed findings

- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

Before our inspection we reviewed a range of information we hold about the practice from our Intelligent Monitoring System. We met with NHS England, NHS Lewisham Clinical Commissioning Group (CCG) and Healthwatch Lewisham and reviewed the information they gave to us. We looked at the practice website for details of the staff employed and the services provided.

We carried out an announced inspection visit on 7 July 2014.

During our inspection we spoke with a range of staff including GP's, nurses, health care assistants and management, administration and reception staff. We also spoke with patients and a representative from the practice's patient reference group (PRG). We looked around the building, checked storage of records, operational practices and emergency arrangements. We reviewed policies and procedures, practice maintenance records, infection control audits, clinical audits, significant events records, staff recruitment and training records, meeting minutes and complaints. We observed how staff greeted and spoke with patients attending appointments and when telephoning the surgery. We reviewed Care Quality Commission (CQC) comment cards completed by patients who attended the practice on the day of our visit.

Are services safe?

Our findings

Safe Track Record

The practice had mechanisms in place for the reporting, recording, investigating and sharing of safety incidents and significant event outcomes. Staff we spoke with described their role and responsibilities in the incident reporting process and confirmed the actions they would take if an incident occurred. We saw records of incidents that had occurred that demonstrated the reporting and investigation processes followed. This included analyses of incidents undertaken, corrective measures implemented and dissemination of learning outcomes to practice staff.

Learning and improvement from safety incidents

The practice had procedures in place to review and learn from significant incidents. Significant events were discussed at the weekly clinical meeting during which occurrences were shared and responsive actions considered. An annual meeting attended by clinical and non-clinical staff was held during which significant events reported throughout the previous year, were reviewed and reflected upon. Minutes from the last annual meeting held in March 2013, documented the significant events that had occurred during 2012, the actions taken in response and lessons learnt. We were told that minutes of the meeting were circulated to all practice staff to ensure that learning outcomes were disseminated.

Reliable safety systems and processes including safeguarding

The practice had safeguarding policies and procedures in place that included the processes for staff to follow should they have concerns about a patient in their care. This included the named contact details of external safeguarding teams for advice and reporting of concerns. The practice held monthly in house safe guarding meetings with the health visitor to discuss any vulnerable children. The practice was represented at local safe guarding board meetings with the local safeguarding team.

Records showed that GP's had completed child protection training at Level 3, nurses at Level 2 and non-clinical staff at level 1, although collective training records maintained were incomplete for some staff. Staff had received online safeguarding vulnerable adults training. Staff we spoke with demonstrated an understanding and knowledge in recognising the potential signs of abuse and the actions they would take if they suspected a child or vulnerable

adult was at risk of harm. They told us they would discuss any concerns with the GP partner and were aware of who to contact within the NHS Lewisham Clinical Commissioning Group (CCG) if they needed further advice.

All new staff employed at the practice were issued with a staff handbook which included a whistleblowing policy to follow if they had any concerns about the services provided. Staff we spoke with were aware of the policy and knew who to speak to if they had concerns about a colleague or the service.

Monitoring Safety & Responding to Risk

The practice had systems in place to identify, assess and manage risks related to the service.

There were arrangements in place to deal with foreseeable medical emergencies. Staff we spoke with and records confirmed that all staff at the practice had undertaken basic life support training.

There was equipment and medicines for use in medical emergencies. Oxygen, emergency drugs and a nebuliser were kept in the ground floor area of the practice. Records showed that the oxygen cylinder was regularly checked by nursing staff. Emergency medicines were regularly monitored to check they were still within the stated expiry date so as to ensure their effectiveness. The practice did not have a defibrillator, however it was practice policy to immediately contact the emergency services if the situation arose.

An anaphylaxis pack and instructions for use were kept in all clinical and treatment rooms. A page alarm system was in operation across the practice to alert staff in the event of a medical emergency. Staff we spoke with were aware of the medical emergency measures in place.

We were told that environmental risk assessments were conducted by the practice although we were unable to verify the assessments conducted. We saw a document which confirmed that the premises did not require a legionnaires test as the air conditioning units were a refrigerant system and therefore did not carry any risk.

Medicines Management

The practice had one clinical fridge where vaccinations and other types of injections were stored.

Temperature checks of the fridge were carried out daily to ensure that vaccinations were stored within the correct

Are services safe?

temperature range. Records were maintained of daily internal and external temperature readings. Nursing staff we spoke with were aware of the process to follow if the fridge temperature ever breached the recommended range.

Records demonstrated that the fridge was serviced annually. However it was noted that although the fridge used was lockable it was kept unlocked. Relevant staff we spoke with in relation to this were unsure of where the fridge key was kept.

There was a designated practice nurse who was responsible for ordering and the safe storage of vaccinations. This included medicine stock rotation to ensure that new stock was placed in the fridge behind older stock and regular monitoring of vaccination expiry dates. Monthly records were maintained to log vaccines ordered and used.

We reviewed patient group directions (PGD) retained by the practice (A PGD is a specific written instruction for the supply and administration of a licensed named medicine, to specific groups of patients who may not be individually identified before presenting for treatment. PGD's should only be used by a registered nurse or midwife who has been assessed as competent and whose name is identified within each document). We saw that it had been correctly completed and updated in April 2014 for the administration of typhoid vaccines, flu vaccinations and Hepatitis A and B vaccinations.

We were informed that patient specific directions were completed case-by-case. A patient specific direction (PSD) is a written instruction, signed by a doctor, for medicines to be supplied and/or administered to a named patient after a patient has been assessed. For example, a patient prescribed vitamin B12 injections by a GP for administration by a qualified and competency assessed nurse.

Cleanliness & Infection Control

There was a lead nurse responsible for infection prevention and control (IPC). Appropriate personal protective equipment (PPE), such as latex and non latex gloves and aprons, were available in all clinical areas and staff were aware of the principles of wearing and disposing of PPE. The practice generated two types of waste; clinical and domestic, and these were correctly segregated. There were

disposable curtains around examination couches which had recently been changed. Staff we spoke with were aware of the practice policy for managing spillages in the premises and knew where the spillage kit was stored.

There was a daily general cleaning rota available but this was not signed or initialled and therefore we were unable to assess if the cleaning schedule was adhered to. The practice did not have a deep clean rota.

The practice could not demonstrate the use of the colour coded cleaning materials and equipment. There were no colour coded mops, buckets or cloths for cleaning different areas in the practice. This was brought to the attention of the practice manager who was already aware and investigating the issue as part of an action plan agreed following a recent external infection control audit conducted four days prior to our visit. It was noted that no other issues were identified during this audit.

Staffing & Recruitment

There were processes in place for the recruitment of staff to check their suitability to work in a health care environment. Recruitment checks had been carried out for staff who worked at the practice. These included references, identity checks and confirmation of registration with professional bodies. Of the three staff files we reviewed we found evidence in only one file of a completed disclosure and barring (DBS) check. There was no record of a DBS check in the practice nurse and receptionist recruitment files we reviewed. The practice did not provide any further information to confirm that DBS checks had been appropriately undertaken for all staff.

The practice had a mandatory induction programme for staff tailored to their roles and responsibilities. We saw a copy of the induction programme form for reception staff. This included chaperone training, health and safety incorporating infection control, clinical waste and incident recording.

Dealing with Emergencies

The practice had a business contingency plan to deal with any potential disruption to service. The plan covered areas of system failure including disruption to information technology (IT) and electronic systems and replacement of clinical and administration staff to cover absence. Although the contingency plan was reviewed yearly, we noted the contact list did not include contact details for the NHS

Are services safe?

Lewisham Clinical Commissioning Group (CCG) or details for IT support. There was an agreement with other local practices to support each other and keep services running if required.

Equipment

We were told that medical equipment was tested and calibrated every year and that electrical equipment had an

annual portable appliance test, but we did not see records to confirm this. We did see records which demonstrated that the fridge used to store vaccinations was serviced annually. The practice did not provide us with records to demonstrate that building maintenance checks were up to date and complete.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

The practice provided care in line with national guidance. Clinical staff had access to up-to-date National Institute for Health and Care Excellence (NICE) guidance online. They also had on line access to the general practice notebook, a medical reference resource continually updated. The practice held weekly clinical meetings for staff to discuss complex cases and review new guidance to ensure they were up-to-date with current evidence based medicine.

The practice was involved in the training and development of trainee GP registrars and had been approved as a training practice by the London Deanery, the local training body for doctors. The GP registrar attended joint clinics with their GP trainer. This enabled the trainee to be observed and receive feedback provided in order to promote learning and best practice. The trainee GP registrar spoke highly about the training received at the practice and would recommend it as a training practice. .

Management, monitoring and improving outcomes for people

The practice undertook clinical audits in addition to the national quality and outcome framework (QOF) requirements, to drive improvement and ensure best practice care and treatment.

We saw evidence of closed loop clinical auditing undertaken. Closed loop clinical audit is a cyclical process that compares current practice against evidenced based standards and makes recommendations to improve practice which are implemented and then re-audited to measure improvement. One recent audit conducted by the practice trainee GP registrar, reviewed the documentation of skin lesions in patient's notes and National Institute for Health and Care Excellence (NICE) criteria for urgent referral to dermatology. The audit found that detailed documentation about skin lesions were not being made in notes. As a result a template was designed for GP's to use when reviewing patients with skin lesions. The subsequent re-audit demonstrated improvement in documentation and performance.

The practice held review meetings, at least annually, with the NHS Lewisham Clinical Commissioning Group (CCG) prescribing advisor. The practice participated in the Quality

and Outcomes Framework (QOF). This is a voluntary incentive scheme for GP practices used to monitor the quality of services provided against groups of key performance indicators to improve practice. As part of the medicines management actions in the QOF scheme (now replaced by the Prescribing Incentive Quality Scheme (PIQS) from April 2013), all practices who participated in the scheme, were required to complete audits of three prescribing areas. This was to ensure prescribing practices were in line with current best practice. We saw an example of an audit completed by the practice under the QOF scheme, in which prescribing improvements had been made. For example, following identification of over prescribing of a type of antibiotic, the practice had reduced the course of antibiotic treatment in uncomplicated urinary tract infection (UTI) to three days in line with current guidelines.

The practice undertook regular monitoring of referrals made to external services to ensure that they were appropriate to meet patient needs and improve outcomes. Referrals were discussed by the clinical staff at daily lunchtime meetings and weekly clinical meetings and re-directed to more appropriate services if required. The practice had also been involved in the NHS Lewisham Clinical Commissioning Group (CCG) led referral review scheme. This involved the monthly review of a selection of referrals to ensure they were in line with current guidance and opinion. For example, fifteen referrals were reviewed from May to July 2014 and all were found to be in accordance with current guidelines.

There was a system in place to review repeat prescriptions and ensure that recurrent medicines prescribed to patients remained appropriate for their care. All patients' repeat prescriptions were reviewed annually and more frequently if the patient was prescribed more than four medicines. There was a system of re-call requests on patients file and letters would be sent to invite them for a review.

Effective Staffing, equipment and facilities

All clinical and administration staff had received training appropriate to their roles. We reviewed a selection of staff files and saw up-to-date training certificates and records in all files for example, in basic life support, infection control and safeguarding.

Administration staff at the practice had annual staff appraisal meetings to review performance and identify any additional training needs. Staff told us the management

Are services effective?

(for example, treatment is effective)

team were supportive of their training needs and career development. Nursing staff also took part in annual appraisal and told us they were supported in learning and development. However, we did not find any personal development plans in the staff files that were reviewed.

GP trainee registrars were supervised by the partner GP trainer and took part in regular joint surgeries with their trainer for observation and feedback. They also took part in daily debriefs with their supervisor to discuss cases. Debriefs occurred less frequently as the trainee gained more clinical experience. Nursing staff however told us they had no formal supervision in the practice. They had access to support and supervision from the NHS Lewisham Clinical Commissioning Group (CCG) practice nurse advisor and attended a practice nurse forum every two months for feedback.

Clinical staff had access to the necessary medical equipment to provide a complete service to meet the needs of their patients. Spirometry, a test of lung function, was performed in house by trained health care assistants (HCAs) as part of the asthma and chronic obstructive pulmonary disease (COPD) monitoring the practice provided. Minor surgery was offered by trained clinicians and they had access to a local 24 hour ECG service.

Working with other services

The practice had links with community based services to plan integrated care pathways for their patients. Community based nurses, including a health visitor, palliative care nurses and district nurses rotated attendance at weekly clinical practice meetings. A monthly multi-disciplinary team meeting was held at the practice with allied professionals in attendance, including district nurse's community matron and social workers. Patients with complex needs were discussed at these meetings to plan co-ordinated care.

Minutes of a recent meeting demonstrated that information was shared between the clinical teams and actions plans developed for each patient. There was also a six weekly meeting with the palliative care nurse to discuss and support the needs of patients receiving end of life care.

The practice worked with other GP practices in the area as part of the NHS Lewisham Clinical Commissioning Group

(CCG) initiative to prevent avoidable hospital admissions. The GP partner attended a forum with eighteen local GP practices and worked together with district nurses, community nurse specialists and external agencies. The aim was to prevent unnecessary admission of patients to hospital where their needs could be met at home.

Health Promotion & Prevention

The practice had measures in place for health promotion and prevention in their patient population.

The practice nurse ran a flu immunisation clinic. Alerts were placed on targeted patients records and letters were sent out to invite them to attend for immunisation. The practice had good uptakes rates of childhood immunisations with 80% uptake of the Measles Mumps and Rubella (MMR) vaccination and 60-70% uptake of pre-school booster vaccinations.

The practice was equipped to provide sexual health screening if required, including Human Immunodeficiency Virus (HIV) testing.

There were measures in place to promote healthy lifestyle choices to patients. Health checks performed by the practice Health Care Assistants (HCA) were offered to patients aged over 40. This involved the measurement of a person's weight, blood pressure and lifestyle habits. Any abnormal values or concerns identified were referred to the patient's usual GP. The HCA's performed weekly home visits on a Wednesday to carry out health checks for patients who were house bound. New patients who registered with the practice were invited to new patient clinics to review medical history and lifestyle factors.

The practice was pro-active in addressing weight related health problems and patients were offered a referral to weight watchers for a free 12 week programme. A community dietician held a weekly session within the practice building and would review patients and children with an identified need.

There was a HCA led smoking cessation clinic offering one to one advice and a full range of treatments to support patients to stop smoking.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

The results of the 2013 National GP patient survey showed 76% of respondents felt the last GP they saw or spoke with treated them with care and concern and 73% felt the last nurse they saw or spoke with treated them with care and concern. 55% of respondents were satisfied with the level of privacy when speaking with reception staff at the practice.

Most patients we spoke with told us that staff treated them with dignity and respect. They described positive experiences when they attended the practice. All patients we spoke to told us they were treated compassionately by staff and that their confidentiality was respected. However, some patients told us that not all reception staff were polite and on occasions could be rude.

Patients who completed Care Quality Commission (CQC) comments cards commented positively about the care received. Staff were described as “competent”, “friendly”, “respectful”, “understanding” and “helpful”.

Some patients expressed difficulties accessing appointments and said that this negatively affected their overall experience.

We spent some time observing reception staff while answering telephone calls from patients and when dealing with patients who attended in person. We observed that they treated patients with courtesy and respect and responded to them in a professional manner.

Consultations took place in appropriately equipped rooms that maintained patient’s privacy and dignity. A chaperone service was available to patients if required and information about this service was displayed in the patient waiting area. Reception staff told us that they would act as a chaperone in the event that a practice nurse or

healthcare assistant was not available. One member of the reception team informed us they had received chaperone training at another practice, but we could not verify if all reception staff had received similar training.

Following the death of a patient the practice would send a written letter to the next of kin to offer condolence and support if needed.

Involvement in decisions and consent

Patient information leaflets provided by the practice presented details of patients’ rights and responsibilities as a patient. The leaflets identified patients’ rights relating to consent to treatment. Patients we spoke with told us that GP’s provided them with relevant information and explanations about treatment options.

Patient information and health related literature was available in the reception area. However, we found that notice boards used to display information about the practice, such as notices about the triage system, were positioned above eye level and maybe difficult for patients to read.

We discussed with staff how capacity assessments and Gillick competency assessments of children and young people were undertaken. Gillick competence is used in medical law to decide whether a child 16 years or younger is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Staff we spoke with were aware of their responsibilities in assessing a patient’s maturity and capacity to make decisions about their treatment and care.

Results from the last NHS GP patient survey carried out in 2013 demonstrated that 83 per cent of patients said that the last GP they saw or spoke to was good at explaining tests and treatments. 71 per cent of respondents indicated that their GP was good at involving them in decisions about their care and treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had systems in place to meet the varied needs of patients who used the service. For example, they ran services to meet the needs of expectant mothers and young families. Ante-natal care was provided by visiting community midwives twice a week. A health visitor led child development clinic and GP led post-natal clinic were held weekly. The practice ran an immunisation re-call system for babies and children with access to flexible appointments. Reception staff told us that emergency appointment requests for babies and young children would be discussed with the on-call duty GP, if the complaint did not appear to be urgent. GP telephone triage call back would then be arranged, if required.

The practice had measures in place to meet the needs of patients with chronic conditions, mental health problems and learning disabilities, including annual reviews. Reception staff told us they were aware of the needs of this potentially vulnerable patient group and ensured they were seen in a timely manner if they required an urgent appointment. For example if a patient was prescribed methadone and needed to see a GP urgently they would alert the relevant doctor.

Older patients, those aged over 75 years, had a named GP for their medical management. Home visits were available for patients unable to attend the practice. The practice retained a list of patients who received palliative care so that reception staff were aware and could pass enquiries to the duty GP. Patients had access or could be referred to counselling provided by Lewisham Psychological Therapies Services which were based next door to the practice.

The practice ran annual health checks for patients with learning disabilities and we were told they had strong links with patient carers to ensure they were supported and meeting the needs of their patients. We discussed with nursing staff the provision of smear testing for adult females and were told that this was sometimes a difficult area to address as the practice did not have easy to read literature to explain the procedure.

Staff at the practice told us about the measures they would take to help patients with difficulties to access the service. For example, reception staff told us they knew the patients who had visual impairment and would take them to the

appropriate clinic room when their name was called. The practice was accessible for wheelchair users. However, it was noted that the fire exit at the back of the premises had a single step which could be restrictive for wheelchair users. The practice had access to interpreter services when required.

The practice demonstrated it had made changes to the service for improvement as a result of patient feedback. For example, staff wore photograph identification badges following a suggestion made through the patient questionnaire.

Access to the service

Core surgery opening times were between 8.00am to 6:30pm. The practice was closed daily from 1.00pm – 2.00 pm but there was a pre-recorded message giving patients the direct number to the practice on-call GP. The practice offered a late surgery on a Wednesday with appointments from 6:30-8:00pm for patients who could not attend within normal working hours. This service was advertised in the practice leaflet and website. Home visits were available for patients who were housebound or for patients receiving palliative care.

Routine appointments could be booked up to four weeks in advance by phone and online. Emergency appointments were available daily with the on-call GP. In addition a telephone triage system was available for patients to request a call back from the GP to discuss their problem over the phone. The on call GP could then arrange a face to face appointment if further input was required. All the GP's and current trainee GP registrar were involved in telephone triage activity, with one GP on call each day.

The 2013 National GP patient survey results showed that 80% of respondents were able to secure an appointment last time they tried and 85% felt the last appointment that they were given was convenient.

Some patients we spoke with expressed difficulties getting through to the practice by phone and in accessing timely appointments. The GP partner and management team were aware of this issue and had appointed a further locum GP to commence work from August 2014.

Repeat prescriptions could be requested online through a secure log in on the practice website for those who could not request them in person. Repeat prescriptions could be collected 48 hours after they were requested.

Are services responsive to people's needs?

(for example, to feedback?)

Concerns & Complaints

The practice have a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there is a designated responsible person who handles all complaints in the practice. The complaints policy was detailed in the practice leaflet and on the practice's website. Complaints were dealt with on an individual basis and all complaints were reviewed at an annual complaints review meeting. During this meeting

details of complaints made in the previous year and the actions taken, were discussed and reflected upon. Where necessary proposals for additional improvements were recommended. We were provided with a copy of the latest annual complaints meeting held in February 2013 to support this. For example, in response to a complaint the practice sends letters to inform patients of any changes to their medication. Patients we spoke with were aware of the complaints process.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Leadership & Culture

The practice manager told us the practice's motto was, 'A centre of quality care, providing local services for local people'. Staff we spoke with described a culture of discussion and learning. One member of staff told us, "we strive to do the best we can, always focused on improvement and what can be done better". Staff also said that there was good team working within the practice with an emphasis on sharing information and work load. One of the GPs explained that they divide up prescription requests and queries amongst all the GP's and offer help to the on call GP during busy periods.

Staff felt the practice was generally well managed and patients were treated well. However, one member of staff said there could be more delegation of responsibilities, for example more lead roles.

Governance Arrangements

The practice had systems in place for clinical governance to ensure continued service improvement. Assurance for quality and safety was the responsibility of the GP partner. There were clearly defined roles and accountability amongst staff. The practice undertook clinical audit to review current care against evidence based standards and to identify areas for improvement.

Systems to monitor and improve quality & improvement

The practice undertook clinical audit to monitor and improve the quality of services provided. The practice engaged with NHS Lewisham Clinical Commissioning Group (CCG) led neighbourhood GP practice meetings, to compare data on performance and quality and outcome framework (QOF) results. We reviewed the documents of a recent meeting and saw the practice performed well in all areas measured. For example, the practice had good antibiotic prescribing for the local area.

The practice participated in the quality and outcomes framework system (QOF). This was used to monitor the quality of services and drive service improvement. The practice regularly reviewed complaints and patient feedback and improved services as a result.

Patient Experience & Involvement

The practice was the first in the local area to set up a patient participation group (PPG) in 2000 to gain feedback

from patients who used the service. The PPG held meetings every six weeks to discuss the quality of services provided and identify potential ways in which improvements could be made. The PPG had input into patient questionnaires delivered by the practice. The results of these patient experience questionnaires were collated and displayed on the practice website for members of the public to view.

The practice demonstrated it had made changes to the service for improvement as a result of patient feedback. For example, staff wore photograph identification badges following a suggestion made through the patient questionnaire. We spoke with a PPG member who told us that a recent suggestion proposed to the practice was to change the name of the telephone triage system to 'telephone consultation'. We reviewed the minutes of the last two PPG meetings and saw that it had been agreed for the triage name to be changed, however this was still to be progressed.

The practice website had a 'You Said, We Did' link that updated patients with changes that had been made as a result of patient feedback. We noted though that responses to comments posted on the NHS Choices website were not responded to by the practice.

Practice seeks and acts on feedback from users, public and staff

Staff we spoke with felt generally well supported by the management team at the practice. Feedback was encouraged through weekly practice meetings. Reception staff met three monthly to discuss administrative related topics and this was also used as a forum for feedback. Staff engaged with the patient participation group (PPG). For example, a member of the reception team recently presented the findings of the latest patient surgery at a PPG meeting. Staff were also invited to attend the annual PPG meeting which we were told was a social and business occasion.

The practice closed at lunchtime which provided a daily opportunity for staff to discuss and review any issues or concerns with all colleagues.

Management lead through learning & improvement

The practice had systems in place for continued learning and improvement. An incident reporting system was in place in which incidents were discussed at weekly clinical

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

team meetings and learning identified. All significant events and complaints were reviewed annually and any learning points or changes to procedures were disseminated to all staff.

Staff received annual appraisal to identify training needs. We were told personal development plans were created at staff appraisal to set out individual objectives and goals, but we did not see evidence of these in staff files reviewed.

Staff training needs were identified during annual appraisal and staff we spoke with felt they were supported in professional development. Nursing staff and GP's were entitled to a week of study leave per year for training and development.

Identification & Management of Risk

The practice had plans in place to deal with any significant disruption to services. We were shown the contingency plan which had been updated in 2014. The plan covered a variety of scenarios including computer services failure and disruption to staffing levels. There was an agreement amongst local practices to maintain services in the event of significant disruption.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

The practice had measures in place to meet the needs of older people. Patients over 75 years of age had a named GP for their medical management. The practice wrote to older patients who had attended accident and emergency departments in the previous three months, to invite them for a routine appointment. This was to assess if their needs could have been met more suitably in the community.

The practice had access to local services for memory assessment and community mental health to meet the

needs of older patients with mental health issues such as dementia. It also had links with social services and community matron to ensure older patients received holistic care.

Administration staff we spoke with were aware of older patients who may require assistance when visiting the practice and ensured they received this. For example, one member of staff told us that they would frequently offer assistance to patients with the choose and book appointment system.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

The practice ran annual medical assessment reviews, or sooner if required, for patients with long term conditions. A re-call system was used to flag when a patient was due to be seen and a letter was sent inviting them to book an

appointment. Patients with chronic lung conditions such as asthma and chronic obstructive pulmonary disease (COPD) received in house lung function tests with spirometry performed by the Health Care Assistant (HCA).

The practice nurses reviewed patients with poorly controlled diabetes and were involved with medicine management. For example, they provided advice when patients first commenced insulin treatment.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

The practice had services in place to meet the needs of young people, mothers and families with children. There was a weekly ante-natal clinic ran by community midwives. A health visitor led child development clinic and GP led post-natal clinic were held weekly.

The practice provided childhood immunisations with a good uptake rate. For example, the uptake rate of Measles Mumps and Rubella (MMR) immunisation was 80% and pre-school booster immunisation uptake was 60-70%.

Health promotion for children was supported by the health visitors attending the practice weekly. For example, they would review children with weight related issues and refer to the dietician service if required. GP's were able to seek advice from local Paediatric Consultants via email or telephone.

The practice also held monthly in house safe guarding meetings with the health visitor to discuss any vulnerable patients. The practice was also represented at safe guarding board meetings with the local authority safeguarding team.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

The practice had measures in place to assist working age people access health services. They offered a late appointment only clinic from 6:30 – 8pm every Wednesday for patients who were not able to attend the practice in normal working hours. This was advertised on the practice website and information leaflet.

A telephone triage system was available which allowed patients to request a same day call back from the GP on call for advice over the phone. In addition, routine appointments could be booked up to four weeks in advance meaning time away from work could be planned accordingly.

Repeat prescriptions could be requested online for those unable to attend the practice to arrange this.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

The practice ran annual health checks for patients with learning disabilities with a 90 percent uptake rate. We were told they had strong links with patient carers to ensure they

were supported and meeting the needs of their patients. We discussed with nursing staff the provision of smear testing for adult females and were told that this was sometimes a difficult area to address as the practice did not have easy to read literature to explain the procedure.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

The practice offered annual checks to review patients experiencing poor mental health. These checks were performed by a practice nurse who had received mental health training. The checks included screening for depression and advice on healthy lifestyle choices. Routine

bloods and electrocardiograms (ECG) were performed to monitor for any medicine side effects. The practice nurse was also involved in the administration and monitoring of injectable treatments for mental health conditions. The practice had links with the community mental health team to discuss cases if required.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers Appropriate checks were not carried out before staff commenced work. Regulation 21 (a) (I)
Family planning services	
Maternity and midwifery services	
Surgical procedures	
Treatment of disease, disorder or injury	